These charges are only allegations which may be contested by the licensee in an administrative hearing.

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

DAVID BURNS, M.D.

STATEMENT

OF

CHARGES

David Burns, M.D., the Respondent, was authorized to practice medicine in New York State on or about August 15, 1988, by the issuance of license number 175860 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A, who had a history of malignant neoplastic disease, anxiety disorder, and chronic pain, from in or about March 2011 through in or about May 2016. Respondent prescribed Xanax, Fentanyl, Adderall, Belsomra, and Omeprazole for Patient A. Respondent engaged in a personal and sexual relationship with Patient A, who died in 2018. (Patient names are listed in the Appendix.) Respondents care and treatment deviated from minimally accepted standards of care in that he:

1. Engaged in a personal and sexual relationship with the patient.

2. Failed to:

   a. appropriately evaluate the patient including but not limited to performing and noting adequate histories and appropriate physical examinations,

b. appropriately monitor the patient's use of narcotics by checking I-Stop, and

c. maintain an accurate record that reflects the care and treatment rendered to the patient.

3. Inappropriately:

a. prescribed medications/controlled substances and/or modified dosages, without adequate justification, without appropriate intervals of in-person office visits and, at the same time,

b. revealed confidential information about the patient to another patient, and

c. documented patient information, in hospital notes, indicating:

i. that the patient suffered from dyspepsia and had previous proton pump inhibitor therapy, which is not noted anywhere else in the record, and

ii. lower dosing of Fentanyl and Xanax, than his actual prescriptions.

B. Respondent treated Patient B, who complained of fibromyalgia and chronic pain, from in or about January 2011 through in or about April 2016. Respondent prescribed Oxycodone and Xanax for Patient B. Respondent engaged in a personal and sexual relationship with Patient B. Respondent's care and treatment deviated from minimally accepted standards of care in that he:

1. Engaged in a personal and sexual relationship with the patient.

2. Failed to appropriately:

a. evaluate the patient and clearly demonstrate what symptoms related to which diagnoses,

b. perform and/or document annual histories and physical examinations, and document annual recommendations including but not limited to vaccinations, screening mammography, periodic bone density and colonoscopy testing,

c. recognize a potential side effect to Bactrim and add this antibiotic to the patient's list of allergies,

d. send the patient to an emergency room for thorough evaluation and monitoring of symptoms in September 2014,

e. attempt treatment alternatives including but not limited to other medications and/or therapists,

f. refer the patient to, and/or recommend consultations with, physical therapy, addiction specialist, pain management specialist, mental health provider, rheumatologist, orthopedist, cognitive behavioral therapy, and/or other alternative care practices, and

g. maintain a record that accurately reflects the care and treatment rendered to the patient.

3. Inappropriately prescribed:

a. controlled substances and/or modified dosages, without adequate justification,

b. inconsistent doses of medications, without adequate medical rationale,

c. excessively high doses of Oxycodone and/or Xanax,

d. opioids to treat the patient's fibromyalgia, and

e. IV Toradol and IV Dilaudid and Meclizine, for a possible first migraine in a 57-year-old with no history of migraines.

C. Respondent treated Patient C, who had a history of anxiety, chronic pain, back pain, Vitamin B deficiency, and Reflux disease, from in or about August 2013 through in or about May 2016. Respondent prescribed Klonopin, Oxycodone/Percocet, and Ambien for Patient C. Respondent's care and treatment deviated from minimally accepted standards of care in that he:

1. Failed to appropriately:

a. follow-up on the patient's complaint of chest pain and visit to the ER in September 2014,

b. evaluate the patient when presenting with a rash in December 2014,

c. refer the patient for psychiatric consultation based on complaints of increased anxiety,

d. follow-up on and/or modify treatment, after being notified that the patient was abusing alcohol and/or narcotics, and

e. maintain a record that accurately reflects the care and treatment rendered to the patient.

2. Inappropriately prescribed:

a. medications/controlled substances, without adequate justification,

b. Ambien, for 76-year-old, taking other centrally acting medications including Percocet and Klonopin, without offering and/or attempting alternative treatment modalities, and

c. refills for controlled substances in less than monthly intervals

D. Respondent treated Patient D, who had a history of anxiety, chronic pain, hemorrhoids, irritable bowel syndrome, and shoulder joint pain, from in or about February 2011 through in or about June 2016. Respondent prescribed Vicodin, Norco, Soma, and Xanax for Patient D. Respondent's care and treatment deviated from minimally accepted standards of care in that he:

1. Failed to appropriately:

a. evaluate the patient including but not limited to performing and/or noting adequate histories and appropriate physical exams,

b. follow-up on the patient's diagnosis of uterine cancer, treatment, and status of that condition, and/or the patient's neck/back pain,

c. demonstrate medical necessity, in medical clearance for shoulder surgery, particularly in light of a documented normal exam,

d. evaluate patient's report of syncope, days before elective surgery, and order and/or perform a thorough work-up, and

e. maintain a record that accurately reflects the care and treatment rendered to the patient.

2. Inappropriately:

a. prescribed medications/controlled substances, and modified prescriptions, without adequate justification,

b. prescribed the maximum dose of Acetaminophen, and

c. documented, in medical clearance for a hysterectomy, wrong dosing for Xanax and Soma, that the patient was on Axert which is not noted anywhere in the record, and that the patient is hypothyroid, when she was hyperthyroid.

E. Respondent treated Patient E, who had a history of diabetes, obesity, anxiety, insomnia, hypertension, and chronic pain, from in or about January 2011 through in or about April 2016. Respondent prescribed Hydrocodone, Oxycodone, Ambien, and Xanax for Patient E. Respondent's care and treatment deviated from minimally accepted standards in that he:

1. Failed to appropriately:

a. evaluate the patient including but not limited to performing and/or noting adequate histories and appropriate physical exams,

b. make recommendations:

i. regarding diet and weight loss,

ii. on how to handle anticoagulation dosing prior to scheduled surgery,

iii. for a follow-up colonoscopy in 3 years, after an adenomatous polyp was removed, and

iv. to consult with a dermatologist for a rash, and

c. maintain a record that accurately reflects the care and treatment rendered to the patient.

2. Inappropriately:

a. prescribed the maximum dose of Lortab/Hydrocodone and/or Percocet, in conjunction with Oxycodone-Acetaminophen combination tablets, without appropriate warning to the patient, and

b. documented, in pre-op evaluations for a hip replacement and then a knee replacement, that there was no history of diabetes, smoking, or alcohol use, which are all inconsistent with the medical record.

SPECIFICATION OF CHARGES
FIRST-SECOND SPECIFICATIONS

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(20) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following:

1. Paragraphs A and A1.

2. Paragraphs B and B1.

THIRD-FOURTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

3. Paragraph A and its subparagraphs.

4. Paragraph B and its subparagraphs.

FIFTH-NINTH SPECIFICATIONS

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of:

5. Paragraph A and its subparagraphs.

6. Paragraph B and its subparagraphs.

7. Paragraph C and its subparagraphs.

8. Paragraph D and its subparagraphs.

9. Paragraph E and its subparagraphs.

TENTH-FOURTEENTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, as alleged in the facts of:

10. Paragraph A and A2c.

11. Paragraph B and B2g.

12. Paragraph C and C1e.

13. Paragraph D and D1e.

14. Paragraph E and E1c.

FIFTEENTH SPECIFICATION

REVEALING INFORMATION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(23) by revealing information obtained in a professional capacity without the prior consent of the patient, as alleged in the facts of:

15. Paragraph A and A3b.

DATE: March 28, 2023
New York, New York

[redacted]

HENRY WEINTRAUB
Chief Counsel
Bureau of Professional Medical Conduct